Office of Statewide Health Planning and Development
HOSPITAL ANNUAL DISCLOSURE REPORT
SUMMARY OF CHANGES
FOR REPORT PERIODS ENDING ON OR AFTER JUNE 30, 2003

The 29th year (2003-04) hospital annual reporting requirements have not changed from the previous disclosure cycle, except for changing the date in the bottom, right-hand corner of each report page to "(6-2003)".

Significant changes were made, however, in the 26th year (2000-01) disclosure cycle. Below is a summary of the changes to the reporting requirements, which were authorized with the issuance of Hospital Transmittal Letters No. 8 (October 1998) and No. 9 (April 2000). The focus of the changes was the establishment of new payer categories to account and report the activities associated with patients enrolled in managed care health plans. For each payer category, hospitals will be required to report patient days and discharges by type of care and outpatient visits by type of visit (report page 4), and gross inpatient and outpatient revenue by revenue center, and related deductions from revenue (report page 12).

The new payer categories include Medicare - Managed Care, Medi-Cal - Managed Care, County Indigent Programs - Managed Care, and Other Third Parties - Managed Care. We also established an Other Indigent payer category to separately account and report those indigent patients who are not the responsibility of a county Section 17000 obligation. These indigent patients were formerly included in the Other Payers category.

The existing Medicare, Medi-Cal, and County Indigent Programs payer categories have the same definition, but have the word “Traditional” added to distinguish them from their managed care counterparts. The Other Third Parties payer category has been renamed Other Third Parties - Traditional, and now excludes all managed care health plans. Although the Other Payers category retains the same name, it now excludes non-county indigent patients. A complete list of the 10 required payer categories follows:

Medicare - Traditional
Medicare - Managed Care
Medi-Cal - Traditional
Medi-Cal - Managed Care
County Indigent Programs - Traditional
County Indigent Programs - Managed Care
Other Third Parties - Traditional
Other Third Parties - Managed Care
Other Indigent
Other Payers

We made the following changes to the Hospital Annual Disclosure Report: in 2000:

Report Page 3.3 - Related Hospital Information

- Deleted lines 67, 68, and 69 related to managed care patient days and outpatient visits. Managed care data related to patient days and outpatient visits are included in the new report page 4.1 - Patient Utilization Statistics by Payer.

Report Page 4 - Patient Utilization Statistics

- Old report pages 4.1 and 4.2 were combined as new report page 4.

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Report Page 4 (continued)

- Patient days and discharges by payer category and by cost center for Daily Hospital Services were deleted (lines 5 through 155; columns 6 through 10, and columns 13 through 17). Adult and pediatric patient days, and service and hospital discharges are still required to be reported by Daily Hospital Services cost center.

- Nursery days and discharges (line 155, columns 5 and 12) were moved to new report page 4.1 - Patient Utilization Statistics by Payer, line 40.

- Inpatient and Outpatient utilization statistics by payer category and by cost center for Ambulatory Services, Ancillary Services, and Other Statistics were deleted (lines 160 through 560; columns 2 through 6, and columns 8 through 12).

- Purchased Inpatient Services days (line 410) was moved to new report page 4.1 - Patient Utilization Statistics by Payer, line 45.

New Report Page 4.1 - Patient Utilization Statistics by Payer

- This new page requires payer category detail for patient days and discharges by type of care (lines 5 through 45, columns 1 through 22). The types of care reported are Acute Care, Psychiatric Care, Chemical Dependency Care, Rehabilitation Care, Long-Term Care, and Other Care. Also included are Nursery Acute and Purchased Inpatient Services.

- Payer category detail for outpatient visits by type of visit is also required (lines 60 through 105, columns 1 through 11). The types of visit include Emergency Services, Clinics, Observation Care, Psychiatric Day/Night Care, Home Health Care, Hospice – Outpatient, Outpatient Surgeries, Private Referred, and Other.

Report Page 8 - Statement of Income - Unrestricted Fund

- Combined report page 8.1 with report page 8, renumbering the nonoperating revenue and expense lines to line 500 through 705 (Section III).

- Deleted Purchased Inpatient Services revenue (line 20). Purchased Inpatient Services revenue provided no meaningful information and distorted the calculations resulting from the cost allocation process.

- Moved the detail for deductions from revenue to lines 300 through 385 (Section II).

- Capitation premium revenue was separated from deductions from revenue. Capitation premium revenue must be reported by managed care payer category on lines 430 through 445 (Section II) and in total on line 107.

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Report Page 8 - Statement of Income - Unrestricted Fund (continued)

- The operating expenses were changed from natural classification of expense to functional service (lines 146, 151, 156, 161, 166, 171, 176, 181, 186, 190 and 195).

Report Page 12 - Supplemental Patient Revenue Information

- Inserted 10 columns for inpatient and outpatient gross patient revenue and deductions from revenue related to the new payer categories.
- Renumbered the columns of the report page to be columns 1 through 23.
- Deleted Purchased Inpatient Services revenue (line 410). Purchased Inpatient Services revenue provided no meaningful information and distorted the calculations resulting from the cost allocation process.
- Separated Capitation Premium Revenue from deductions from revenue (line 457). These amounts were formerly reported as negative amounts on line 427.

Page 17 - Trial balance Worksheet and Supplemental Expense Information - Patient Revenue Producing Centers

- Added Purchased Outpatient Services expense (line 411) to separately identify these managed care services from outpatient managed care services provided within the hospital.

Page 19a - Cost Allocation - Statistical Basis

- Deleted Purchased Outpatient Services statistics (line 910) .